CMS Referral for Own Motion Review by DAB/MAC

Appellant at ALJ Level

Sidney Vision Clinic, LLC

Beneficiary (if not the Appellant)  List attached

ALJ Appeal Number

1-776529312, 1-776546647

ALJ Decision Date

December 20, 2011

Health Insurance Claim Number (HICN)*

Specific Item(s) OR Service(s)

67820 (correction of trichiasis)

Provider, Practitioner OR Supplier

Sidney Vision Clinic, LLC

Part A  Part B

Basis for referral

Any Case  CMS as a Participant  Pre-BIPA

☒ Error of law material to the outcome of the claim

☐ Decision not supported by the preponderance of evidence

☐ Abuse of discretion

☐ Broad policy or procedural issue of public interest

☐ Abuse of discretion

Background and Rationale for Referral:

Sidney Vision Clinic, LLC (Appellant) submitted two claims to Medicare for revision of eyelash services furnished to a single Medicare beneficiary using Current Procedural Terminology (CPT) code 67820 (correction of trichiasis; epilation, by forceps only). For date of service September 2, 2010, the Appellant billed for 15 units of 67820 and for date of service November 18, 2010 the Appellant billed for 29. Medicare initially paid for two units for each date of service but denied the remaining quantity because the number of services billed was greater than what submitted information supports. Exh 3 at 12.

The Appellant requested redeterminations regarding denials of the remaining units, arguing payment for multiple units was warranted because:

This a rare incidence, where a patient has individual lashes growing from his lash base into his cornea, causing extreme pain and corneal abrasion. Each lash has to be surgically removed immediately, or infection sets in. We cannot perform the procedure 2 lashes at a time, as Medicare allows. [Number of lashes] were medically necessary to remove on [date of service]. Please remit payment.

Exh 3 at 11. In the redetermination decisions, Wisconsin Physician Services, the Medicare administrative contractor (MAC), found the remaining units could not be paid

1 We cite the administrative record in appeal 1-776546647. The bases for denial and appeal and the ALJ decisions are substantially similar in both cases.

The ALJ decision and case file(s) are enclosed.  X  Additional sheet(s) attached

Signature

Date of Referral

Lawson Blanton, JD

February 15, 2012

Contractor effectuation will be delayed until the Departmental Appeals Board issues its decision.
because “The billing of this code is for the removal of lashes to the eyelids of the eye. It is not to be billed for each individual lash removed.” Exh 3 at 2. The MAC also found one of the two initially paid units paid in error and subsequently recouped the overpayment. Id. The MAC held the Appellant responsible for the denied services. Id.

In its request for reconsideration, the Appellant again requested that it be paid one unit per eye lash as billed. Exh 4 at 2 and 4. In the April 26, 2011 reconsideration decision letter, the qualified independent contractor (QIC) upheld the denials stating the Appellant had been paid for one service and “[t]he documentation does not support payment of [number of] units of service…Procedure code 67820 is not used for individual eyelash removal. Therefore, payment cannot be allowed for the procedures in question.” Exh 5 at 4. The QIC held the Appellant liable for the overpaid amount and the denied services. Id.

The Appellant initially requested hearings before an Administrative Law Judge (ALJ), although it later waived its right to a hearing and requested on-the-record decisions. Exh 6 at 1.² In the December 20, 2011 decision favorable letters, the ALJ determined each eye lash was separately payable as billed. ALJ decision at 6-7. The ALJ explained:

Previously, the claim was denied on the basis that information in the file does not support correction of trichiasis (67820) for 28 units. Medicare paid for one (1) unit. The office note in Ex., 1 and the appeal letter from Dr. Jeffrey Cook indicates that [the beneficiary] presented to him with symptoms of extreme pain and photophobia in the right eye. [The beneficiary] had multiple corneal abrasions, due to senile entropion with trichiasis. In order to elevate [sic] the pain, 29 lashes³ had to be surgically removed with forceps. Ex. 6. Based on the record, the ALJ finds that Medicare payment is warranted for the services as billed by the Appellant.

With regard to Section 1879 of the Act, the ALJ determined, “the services are determined medically reasonable and necessary based on the medical evidence. Thus, the provisions contained in Section 1879 are not necessary for consideration.” Id.

The ALJ erred in allowing payment for all billed units of service on the basis that the services were reasonable and necessary. The claims were not denied because services were not reasonable and necessary, but because payment for one unit of 67820 constitutes payment for the full procedure. According to a July 1998 CPT Assistant article, “codes 67820 and 67825 are intended to be reported per procedure, not per eyelash or per eyelid.” The services at issue are paid under the physician fee schedule, which establishes uniform national payment amounts for each defined service, based on relative value units for physicians’ work, practice expense, and malpractice insurance. 42 CFR § 414.22. To implement the physician fee schedule, CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. 42 C.F.R. §414.40. CMS has adopted the American

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² The Waiver of Right to an … ALJ Hearing form is located behind the ALJ decision.
³ The decision in appeal 1-776529312 addresses removal of 15 lashes.
Medical Association (AMA)’s CPT-4 as the standard medical data code set for reporting physician services. 45 CFR 162.1002(a)(5). Thus, official AMA coding guidance instructs that 67820 is paid per encounter and not per eyelash. Section 1848(i)(1) prohibits review of “the establishment of the system for the coding of physicians' services under this section” as well as CMS's determination of “relative values and relative value units” for physician services paid under the fee schedule. The definition of physician services and payment amounts for those services are not subject to appeal.

Additionally, CMS has implemented a medically unlikely edit (MUE) for 67820 for units of service billed in excess of one. CMS explains, “An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances allowable by the same provider for the same beneficiary on the same date of service. See http://questions.cms.hhs.gov/app/answers/detail/a_id/8734/. The Appellant does not contend that it performed 29 (in appeal 1-776546647) and 15 (in appeal 1-776529312) independent and distinct procedures, but that it is entitled to payment for the number of eyelashes corrected during a single procedure. MUEs are part of CMS' NCCI program and were created under the statutory authority of § 1848(c)(4) as an ancillary policy to implement the nationwide physician fee schedule effectively. Allowing the additional units eyelash correction) above one per procedure contradicts MUE coding and payment policies, circumvents CMS’s determination of payment amounts for physician services and constitutes a review of the “relative values and relative value units” CMS has assigned to those services.

Applicable Law, Regulation, and Medicare Policy:

Section 1848 of the Act establishes that payment for physician’s services is based on a fee schedule. Section 1848(b) authorizes the Secretary to establish fee schedules annually based on the “relative value for the service, the conversion factor, and the geographic adjustment factor.” In order to correctly determine the amount to be paid, the Secretary is authorized to “establish a uniform procedure coding system for the coding of all physicians’ services” under § 1848(c)(5). The uniform coding system includes national definitions of services, codes to represent services, and payment modifiers to the codes. 42 C.F.R. § 414.40(a).

45 CFR 162.1002(a)(5) identifies CPT-4 as the standard medical data code set physician services that CMS has adopted. CPT Codes were designed by the American Medical Association (AMA) to describe medical services and procedures performed by providers. The CPT code system has been incorporated into the Healthcare Common Procedure Coding System (HCPCs) developed by CMS for processing, screening and paying Medicare claims. The AMA publishes annual guidance for CPT coding, including code descriptions, use of modifiers, and coding instructions. CMS explains:

The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians
and other health care professionals. These health care professionals use the CPT to identify
services and procedures for which they bill public or private health insurance programs.
Decisions regarding the addition, deletion, or revision of CPT codes are made by the AMA.
The CPT codes are republished and updated annually by the AMA…”

Http://www.cms.gov/medhcpcsgeninfo/. CMS also provides instructions regarding
correct coding policy in Chapters 12 and 23 of the Medicare Claims Processing Manual
(CMS Pub 100-4) (MCPM) and the National Correct Coding Initiative Policy Manual

Section 1848(i)(1) of the Act precludes administrative or judicial review of “the
establishment of the system for the coding of physicians' services under this section” as
well as “the determination of relative values and relative value units” for physicians’
services. Regulations governing Part A and B fee-for-service appeals reiterate that “Any
issue regarding the computation of the payment amount of program reimbursement of
general applicability for which CMS or a carrier has sole responsibility under Part B
such as the establishment of a fee schedule set forth in part 414 of this chapter,” is not
reviewable. 42 CFR § 405.926(c).

On January 1, 2007, CMS implemented the Medically Unlikely Edit (MUE) program as
part of the NCCI to reduce the error rate for Medicare claims. See CMS FAQs, numbers
NCCI edits generally address improperly billed code pairs, “An MUE for a HCPCS/CPT
code is the maximum number of units of service (UOS) under most circumstances
allowable by the same provider for the same beneficiary on the same date of service.
Units of service in excess of an MUE are denied.” NCCIPM, Chapter 1, General Correct
Coding Policies, V. Medically Unlikely Edits; also
http://questions.cms.hhs.gov/app/answers/detail/a_id/8734/. Pertinent to this case, code
67820 has an MUE for all units of service for greater than one.

Discussion:
The Appellant stated the beneficiary has a painful condition requiring removal of all
affected eyelashes. Exh 6 at 1. The Appellant argued, “This procedure cannot be
managed at 2 lash removals per office visit, as allowed by Medicare standards.” The
Appellant requested review, “as this patient is requiring ongoing medically necessary
care and so that the highest standard of care can be continued.” Id. The ALJ concluded,
“Medicare payment is warranted for medically reasonable and necessary services/items
that are supported by sufficient documentation.” ALJ decision at 7. However, the issue
in this case is not whether it was medically necessary to remove multiple eyelashes.
Rather, the issue is whether the Appellant may bill a separate unit of 67820 for each
eyelash removed.

In a July 1998 CPT Assistant article, the AMA responds to the following question
regarding CPT codes 67820 and 67825:
Question: Do codes 67820 and 97825 represent per eyelash, per eyelid, or per procedure?

AMA Comment: Codes 67820 and 67825 are intended to be reported per procedure, not per eyelash or per eyelid.


CPT code 67820 has also been assigned an MUE of one. According to Medicare coding policies, this means it is medically unlikely the procedure would be completed on a single beneficiary more than once on a single date of service. The AMA’s CPT code descriptions and coding instructions represent CMS’ uniform national definition of services. 42 CFR § 414.40. MUEs are part of CMS’ NCCI program and were created under the statutory authority of § 1848(c)(4) as an ancillary policy to implement the nationwide physician fee schedule effectively. Neither the coding system for physicians' services nor “the determination relative values and relative value units” is subject to review. Section 1848(i)(1) of the Act. For these reasons, the ALJ erred in allowing payment for more than one unit of service per encounter.

Physicians who accept assignment on Medicare claims agree to accept the Medicare allowed amount as payment in full for the services they furnish and agree to charge the beneficiary no more than the deductible and coinsurance for the covered service. 42 CFR § 424.55(b). In the present case, payment for one unit of CPT codes 67820 per date of service constitutes Medicare’s full payment for the procedures performed. The Appellant may not bill the beneficiary for more than the deductible and copayment of the allowed amount for these services.